NOTICE OF SUPPLEMENTAL PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-22-101	Amend
	R9-22-710	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2904 and 36-2239

Implementing statute: A.R.S. §§ 36-2904 and 36-2239

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 3665, September 3, 2004

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4232

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules were amended as result of a 5 Year-Rule Review, finding that the rule relating to capped fee is not required rule language due to the exemption described in A.R.S § 41-1005.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were reviewed.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

AHCCCS anticipates no impact.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS
	Office of Legal Assistance
	701 E. Jefferson, Mail Drop 6200
	Phoenix, AZ 85034
Telephone:	(602) 417-4232
Fax:	(602) 256-6756
E-mail:	AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be is available on the AHCCCS web site www.ahcccs.state.az.us. Please send written comments to the above address by 5:00 p.m., May 31, 2005. E-mail will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	May 31, 2005
Time:	10:00 a.m.
Location:	AHCCCS
	701 East Jefferson
	Phoenix, AZ 85034
	Gold Room
Nature:	Public Hearing

Date:	May 31, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-Term Care System
	110 South Church, Suite 1360
	Tucson, AZ 85701
Nature:	Public Hearing

Date:	May 31, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-Term Care System
	3480 East Route 66

Flagstaff, AZ 86004

Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

42 CFR 447.205, December 19, 1983, R9-22-710

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

ARTICLE 1. DEFINITIONS;

Section
R9-22-101. Location of Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-710. Capped Fee-for-service Payments for Non-hospital Services

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition Section or Citation
"Accommodation" R9-22-107
"Act" R9-22-114
"Active case" R9-22-109
"ADHS" R9-22-112
"Administration" A.R.S. § 36-2901
"Administrative law judge" R9-22-108
"Administrative review" R9-22-108
"Advanced Life Support" or "ALS" R9-25-101
"Adverse action" R9-22-114
"Affiliated corporate organization" R9-22-106
"Aged" 42 U.S.C. 1382c(a)(1)(A) and R9-22-115
"Aggregate" R9-22-107
"AHCCCS" R9-22-101
"AHCCCS inpatient hospital day or days of care" R9-22-107
"AHCCCS registered provider" R9-22-101
"Ambulance" A.R.S. § 36-2201
"Ancillary department" R9-22-107
"Annual assessment period" R9-22-109
"Annual assessment period report" R9-22-109
"Annual enrollment choice" R9-22-117
"Appellant" R9-22-114
"Applicant" R9-22-101
"Application" R9-22-101
"Assignment" R9-22-101
"Attending physician" R9-22-101
"Authorized representative" R9-22-114
"Auto-assignment algorithm" R9-22-117
"Baby Arizona" R9-22-114
"Basic Life Support" or "BLS" R9-25-101
"Behavior management services" R9-22-112
"Behavioral health evaluation" R9-22-112
"Behavioral health medical practitioner" R9-22-112
"Behavioral health professional" R9-20-101
"Behavioral health service" R9-22-112
"Behavioral health technician" R9-20-101
"Behavior management services" R9-22-112

"BHS" R9-22-114
"Billed charges" R9-22-107
"Blind" R9-22-115
"Board-eligible for psychiatry" R9-22-112
"Burial plot" R9-22-114
"Capital costs" R9-22-107
"Capped fee-for-service" R9-22-101
"Caretaker relative" R9-22-114
"Case" R9-22-109
"Case record" R9-22-109
"Case review" R9-22-109
"Cash assistance" R9-22-114
"Categorically-eligible" R9-22-101
"Certified psychiatric nurse practitioner" R9-22-112
"Clean claim" A.R.S. § 36-2904
"Clinical supervision" R9-22-112
"CMDP" R9-22-117
"CMS" R9-22-101
"Complainant" R9-22-108
"Continuous stay" R9-22-101
"Contract" R9-22-101
"Contractor" A.R.S. § 36-2901
"Copayment" R9-22-107
"Corrective action plan" R9-22-109
"Cost-to-charge ratio" R9-22-107
"Covered charges" R9-22-107
"Covered services" R9-22-102
"CPT" R9-22-107
"CRS" R9-22-114
"Cryotherapy" R9-22-120
"Date of eligibility posting" R9-22-107
"Date of notice" R9-22-108
"Day" R9-22-101
"DCSE" R9-22-114
"De novo hearing" 42 CFR 431.201
"Dentures" R9-22-102
"Department" A.R.S. § 36-2901
"Dependent child" A.R.S. § 46-101
"DES" R9-22-101
"Diagnostic services" R9-22-102
"Director" R9-22-101
"Disabled" R9-22-115
"Discussions" R9-22-106
"Disenrollment" R9-22-117
"District" R9-22-109
"DME" R9-22-102
"DRI inflation factor" R9-22-107
"E.P.S.D.T. services" 42 CFR 441 Subpart B
"Eligible person" A.R.S. § 36-2901
"Emergency medical condition" 42 U.S.C. 1396b(v)(3)
"Emergency medical services" R9-22-102
"Emergency services costs" A.R.S. § 36-2903.07
"Encounter" R9-22-107
"Enrollment" R9-22-117
"Enumeration" R9-22-101

"Equity" R9-22-101
"Experimental services" R9-22-101
"Error" R9-22-109
"FAA" R9-22-114
"Facility" R9-22-101
"Factor" 42 CFR 447.10
"FBR" R9-22-101
"Fee-For-Service" or "FFS" R9-28-101
"FESP" R9-22-101
"Finding" R9-22-109
"First-party liability" R9-22-110
"Foster care maintenance payment" 42 U.S.C. 675(4)(A)
"Federal poverty level" ("FPL") A.R.S. § 1-215
"FQHC" R9-22-101
"Grievance" R9-22-108
"GSA" R9-22-101
"Health care practitioner" R9-22-112
"Hearing" R9-22-108
"Hearing aid" R9-22-102
"Home health services" R9-22-102
"Homebound" R9-22-114
"Hospital" R9-22-101
"Intermediate Care Facility for
the Mentally Retarded" or "ICF-MR" 42 CFR 483 Subpart I
"ICU" R9-22-107
"IHS" R9-22-117
"IMD" 42 CFR 435.1009 and R9-22-112
"Income" R9-22-114
"Inmate of a public institution" 42 CFR 435.1009
"Interested party" R9-22-106
"LEEP" R9-22-120
"Level I trauma center" R9-22-2101
"License" or "licensure" R9-22-101
"Mailing date" R9-22-114
"Management evaluation review" R9-22-109
"Medical education costs" R9-22-107
"Medical expense deduction" R9-22-114
"Medical record" R9-22-101
"Medical review" R9-22-107
"Medical services" A.R.S. § 36-401
"Medical supplies" R9-22-102
"Medical support" R9-22-114
"Medically necessary" R9-22-101
"Medicare claim" R9-22-107
"Medicare HMO" R9-22-101
"Member" A.R.S. § 36-2901
"Mental disorder" A.R.S. § 36-501
"New hospital" R9-22-107
"Nursing facility" or "NF" 42 U.S.C. 1396r(a)
"NICU" R9-22-107
"Noncontracting provider" A.R.S. § 36-2901
"Nonparent caretaker relative" R9-22-114
"Notice of Findings" R9-22-109
"OAH" R9-22-108
"Occupational therapy" R9-22-102

"Offeror" R9-22-106
"Ownership interest" 42 CFR 455.101
"Operating costs" R9-22-107
"Outlier" R9-22-107
"Outpatient hospital service" R9-22-107
"Ownership change" R9-22-107
"Partial Care" R9-22-112
"Party" R9-22-108
"Peer group" R9-22-107
"Performance measures" R9-22-109
"Pharmaceutical service" R9-22-102
"Physical therapy" R9-22-102
"Physician" R9-22-102
"Prior period coverage" or "PPC" R9-22-107
"Post-stabilization care services" 42 CFR 422.113
"Practitioner" R9-22-102
"Pre-enrollment process" R9-22-114
"Preponderance of evidence" R9-22-109
"Prescription" R9-22-102
"Primary care provider (PCP)" R9-22-102
"Primary care provider services" R9-22-102
"Prior authorization" R9-22-102
"Private duty nursing services" R9-22-102
"Proposal" R9-22-106
"Prospective rates" R9-22-107
"Prospective rate year" R9-22-107
"Psychiatrist" R9-22-112
"Psychologist" R9-22-112
"Psychosocial rehabilitation services" R9-22-112
"Qualified alien" A.R.S. § 36-2903.03
"Quality management" R9-22-105
"Radiology" R9-22-102
"Random sample" R9-22-109
"RBHA" R9-22-112
"Rebasing" R9-22-107
"Referral" R9-22-101
"Rehabilitation services" R9-22-102
"Reinsurance" R9-22-107
"Remittance advice" R9-22-107
"Resources" R9-22-114
"Respiratory therapy" R9-22-102
"Respondent" R9-22-108
"Responsible offeror" R9-22-106
"Responsive offeror" R9-22-106
"Review" R9-22-114
"Review period" R9-22-109
"RFP" R9-22-106
"Scope of services" R9-22-102
"SDAD" R9-22-107
"Section 1115 Waiver" A.R.S. § 36-2901
"Service location" R9-22-101
"Service site" R9-22-101
"SESP" R9-22-101
"S.O.B.R.A." R9-22-101
"Specialist" R9-22-102

"Specified relative" R9-22-114
"Speech therapy" R9-22-102
"Spendthrift restriction" R9-22-114
"Spouse" R9-22-101
"SSA" 42 CFR 1000.10
"SSI" 42 CFR 435.4
"SSN" R9-22-101
"Stabilize" 42 U.S.C. 1395dd
"Standard of care" R9-22-101
"Sterilization" R9-22-102
"Subcontract" R9-22-101
"Submitted" A.R.S. § 36-2904
"Summary report" R9-22-109
"SVES" R9-22-114
"Third-party" R9-22-110
"Third-party liability" R9-22-110
"Tier" R9-22-107
"Tiered per diem" R9-22-107
"Title IV-D" R9-22-114
"Title IV-E" R9-22-114
"Tolerance level" R9-22-109
"Trauma and Emergency Services Fund" A.R.S. § 36-2903.07
"Tribal Facility" R9-22-101
"Unrecovered trauma readiness costs" R9-22-2101
"Utilization management" R9-22-105
"WWHP" R9-22-120

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

Meets license or certification requirements to provide AHCCCS covered services.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service or equipment provided to a member. A payment is made in accordance with an upper~~,~~ or capped~~,~~ limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) and 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Director" means the Director of the Administration or the Director's designee.

"Eligible person" means a person as defined in A.R.S. § 36-2901.

"Enumeration" means the assignment of a specific nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

"Experimental services" means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States; or

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"FESP" means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"License" or "licensure" means a nontransferable authorization that is awarded based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to lawfully render a health care service.

"Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

"Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or prolong life.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Service location" means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered health care services.

"SESP" means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Spouse" means a person who has entered into a contract of marriage, recognized as valid by Arizona.

"SSN" means social security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

"Tribal Facility" means a facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.

R9-22-710. ~~Capped Fee-for-service~~ Payments for Non-hospital Services

~~A. Service codes. The Administration shall maintain a current copy of the following code manuals at the central office of the Administration for reference use during customary business hours:~~

~~1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS). These manuals identify medical services and procedures performed by physicians and other providers.~~

~~2. The AHCCCS Transportation, Supply, Equipment, and Appliance codes. These codes identify applicable services or supplied items.~~

~~3. The International Classification of Diseases.~~

~~4. Nationally recognized pharmacy coding manual.~~

~~B. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (B)(1) through (5) unless a different fee is specified by contract between the Administration and the provider, or is otherwise required by law. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, effective December 19, 1983, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

~~1. Physician services. Fee schedules for payment for physicians services are on file at the central office of the Administration for reference use during customary business hours.~~

~~2. Pharmacy services. Fee schedules for payment for pharmacy services are exempt from rulemaking procedures under A.R.S. § 41-1005, but are subject to 42 CFR 447.331 through 447.332, effective July 31,~~

1987, which is incorporated by reference and on file with the Administration and the Office of Secretary of State. These incorporations by reference contain no further editions or amendments.

3. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.

4. Transportation services:

a. Ground ambulance services. Fee schedules for payment for ambulance services are on file at the central office of the Administration for reference use during customary business hours. For ambulance providers that have charges established by the Arizona Department of Health Services (ADHS), the fee schedule amount is 80% of the ambulance provider's ADHS approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the fee schedule amount is 80% of the ambulance provider's billed charges or the capped fee for service amount for covered services, whichever is less.

b. Air ambulance services. Fee schedules for payment for air ambulance services are on file at the central office of the Administration for reference use during customary business hours.

c. Nonambulance services. Fee schedules for payment for nonambulance services are on file at the central office of the Administration for reference use during customary business hours.

5. Medical equipment. Fee schedules for payment for medical equipment are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse providers once for durable medical equipment (DME) during any two year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.

C. Capped fee for service medical cost pool and payment. The Administration may establish a capped fee for service medical cost pool for each county in which there are capped fee for service physician contractors. The Administration shall pay all physician fees out of this pool. Fifteen percent of allowable physician fees shall be withheld in the pool. At the end of a contract period, the Administration shall divide any surplus or deficit remaining in the pool evenly between the Administration and the participating physicians subject to the following:

1. The physician withhold shall be used to offset the physician portion of any deficit. Physicians shall not be responsible for any deficit greater than the aggregate amount withheld. The Administration shall return all withholds not needed to fund a deficit on a pro rata basis.

2. The Administration shall divide the physician portion of any surplus so two thirds goes to primary care physicians and one third to referral physicians. These portions shall be divided pro rata among the physicians in each category subject to an upper limit. The physician portion of any surplus is limited so referral physicians receive no more than 115% of the Administration's maximum allowable fees for their services and primary care physicians receive no more than 130%.

~~D. Distribution of funds. The Administration shall make annual settlements of the medical cost pool on an incurred basis. The Administration shall estimate incurred medical costs for a contract period for settlement purposes when three full months of paid claim data can be summarized following the end of the contract period. The settlement shall occur within 105 days following the end of the contract period.~~

~~E. The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.~~

A. Capped Fee for service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. Non contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration capped fee schedule.
2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated by HIPAA, under 45 CFR 160 and 45 CFR 164, at the central office of the Administration for reference use during customary business hours.
   a. Electronic claims must be submitted consistent with federal regulations as described under 45 CFR 160.
   b. Paper claims must be submitted using the National Standard Code Sets required by HIPAA regulations.
   c. Failure to comply with any of the above requirements shall constitute cause for denial of claim.
3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified by contract between the Administration and the provider, or is otherwise required by law.
   a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
   b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
   c. Transportation services - Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours.
   d. Medical supplies and Durable Medical Equipment (DME). Fee schedules for payment for medical supplies and durable medical equipment are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse providers once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.

B. Pharmacy services. The Administration shall only reimburse pharmacy services provided by a contracted provider or a provider having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. The Administration shall reimburse pharmacy services according to the terms of the contract.

C. The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.